West Hills Hospital and Medical Center
7300 Medical Center Drive
West Hills, CA 91307
Telephone: (818) 676-4999
-

KATHLEEN M GOLD
PatID: AF00745510 Age: 48
Acct#: AF1002257625 DOB: 12/17/1966
Printed: 08/21/2015 6:32 PM
By: Sanjay Bhatt, MD Lic: CA107513

# After Care Instructions

INSTRUCTIONS

CHEST PAIN ETIOLOGY UNCLR

1. You have been seen for chest pain. The cause of your pain is not yet known.

2. Your doctor has learned about your medical history, examined you, and checked any tests that were done. Still, it is unclear why you are having pain. The doctor thinks there is only a very small chance that your pain is caused by a life-threatening condition. Later, your primary care doctor might do more tests or check you again.

3. Sometimes chest pain is caused by a dangerous condition, like a heart attack, aorta injury, blood clot in the lung, or collapsed lung. It is unlikely that your pain is caused by a life-threatening condition if: Your chest pain lasts only a few seconds at a time; you are not short of breath, nauseated (sick to your stomach), sweaty, or lightheaded; your pain gets worse when you twist or bend; your pain improves with exercise or hard work.

4. Chest pain is serious. It is VERY IMPORTANT that you follow up with your regular doctor and seek medical attention immediately here or at the nearest Emergency Department if your symptoms become worse or they change.

5. YOU SHOULD SEEK MEDICAL ATTENTION IMMEDIATELY, EITHER HERE OR AT THE NEAREST EMERGENCY DEPARTMENT, IF ANY OF THE FOLLOWING OCCURS:

- Your pain gets worse.
- Your pain makes you short of breath, nauseated, or sweaty.
- Your pain gets worse when you walk, go up stairs, or exert yourself.
- You feel weak, lightheaded, or faint.
- It hurts to breathe.
- Your leg swells.
- Your symptoms get worse or you have new symptoms or concerns.


**PATIENT COPY**

West Hills Hospital and Medical Center
7300 Medical Center Drive
West Hills, CA 91307
Telephone: (818) 676-4999
-

KATHLEEN M GOLD
PatID: AF00745510 Age: 48
Acct#: AF1002257625 DOB: 12/17/1966
Printed: 08/21/2015 6:32 PM
By: Sanjay Bhatt, MD Lic: CA107513

FOLLOW UP

Follow up with your physician 48 hours. Call as soon as possible to arrange.

STATEMENT

I certify that I have received a copy of the above after-care instructions; that these instructions have been explained to me; and that all of my questions pertaining to these instructions have been answered in a satisfactory manner.

Patient/Representative Signature: _____ Staff Signature: _____
Date: 08/21/2015

*PINS*

**PATIENT COPY**

# SPECIALTY ROSTER
## ER PATIENT- PHYSICIAN REFERRAL LIST

| NAME | ADDRESS | TELEPHONE |
|---|---|---|
| Internal Medicine | | |
| Amini, Parviz M.D. | 8435 Reseda Blvd. Northridge, CA 91324 | 818-998-6000 |
| Cabello-Namazie, Giselle M.D. | 1250 La Venta Drive, Suite 207 Westlake, CA 91361 | 805-494-6920 |
| Darush, Alan M.D. | 8540 Reseda Blvd. #103 Northridge, CA 91324 | 818-280-0700 |
| Diehl, Paul E. M.D. | 7320 Woodlake Ave.#270 West Hills, CA 91307 | 818-347-1500 |
| Emzen-Kruger, Kellie M.D. | 1250 La Venta Drive, Suite 207 Westlake, CA 91361 | 805-494-6920 |
| Eshraghi, Rauz A. M.D. | 1250 La Venta Drive, Suite 207 Westlake, CA 91361 | 805-494-6920 |
| Faust, Irene B. M.D. | 7345 Medical Center Dr. #200 West Hills, CA 91307 | 818-888-3416 |
| Feghali, Nabil S. M.D. | 8111 Canoga Ave. Canoga Park, CA 91304 | 818-704-7200 |
| Ficks, Lauren G. M.D. | 1250 La Venta Drive, Suite 207 Westlake, CA 91361 | 805-494-6920 |
| Graham, Geoffrey L. M.D. | 1534 N Moorpark Road Thousand Oaks, CA 91360 | 805-497-1800 |
| Grosser, Jeremy I. M.D. | 9301 Oakdale Ave. #200 Chatsworth, CA 91311 | 818-904-1244 |
| Hage, Christopher N. M.D. | 7345 Medical Center Dr. #220 West Hills, CA 91307 | 818-702-9962 |
| Hanson, Robert M.D. | 22600 Ventura Blvd. #104 Woodland Hills, CA 91364 | 818-225-1617 |
| Hirsch, Caleb W. M.D. | 23101 Sherman Place #500 West Hills, CA 91307 | 818-676-4802 |
| Hirt, Michael M.D. | 5620 Wilbur Ave. #220 Tarzana, CA 91356 | 818-345-2828 |
| Humayun, Saeed M.D. | 23388 Mulholland Drive.-Med Staff Office Woodland Hills, CA 91364 | 818-876-4055 |
| Iqbal, Mohammed I. M.D. | 7345 Medical Center Dr., 6th floor West Hills, CA 91307 | 818-347-2921 |
| Jacobson, Bruce A. M.D. | 7301 Medical Center Dr. #404 West Hills, CA 91307 | 818-347-3239 |
| Kohan, Sid M.D. | 8510 Balboa Blvd., Suite 150 Northridge, CA 91325-5810 | 818-552-6230 |
| Kurtz, Allan L. D.O. | 6325 Topanga Canyon #501 Woodland Hills, CA 91367 | 818-346-1440 |
| Lavin, Marc I. M.D. | 23101 Sherman Place #510 West Hills, CA 91307 | 818-676-4805 |
| Leibzon, Roman M.D. | 1250 La Venta Drive, Suite 207 Westlake, CA 91361 | 805-494-6920 |
| Lin, Jay J. M.D. | 22030 Sherman Way #201 Canoga Park, CA 91303 | 818-883-6840 |
| London, Jeffrey M.D. | 7345 Medical Center Dr. #600 West Hills, CA 91307 | 818-347-2921 |
| Ma, Janet M. M.D. | 1250 La Venta Drive, Suite 207 Westlake, CA 91361 | 805-494-6920 |
| Menteer, Francoise G. M.D. | 29525 Canwood Street #300 Agoura Hills, CA 91301 | 818-706-2477 |
| Mortezai, Mina D.O. | 22554 Ventura Blvd. #201 Woodland Hills, CA 91304 | 818-222-8042 |
| Mortezaiefard, Maryam D.O. | 22554 Ventura Blvd. #201 Woodland Hills, CA 91364 | 818-222-8042 |
| Moshfeghi, Narsis M.D. | 7325 Medical Center Dr. #306 West Hills, CA 91307 | 818-703-7027 |
| Nasim, Sohail M.D. | 7230 Medical Center Dr. #302 West Hills, CA 91307 | 818-227-4272 |
| Newmark, Shelese R. M.D. | 1250 La Venta Drive, Suite 207 Westlake, CA 91361 | 805-494-6920 |
| Nudell, Gary H. M.D. | 23101 Sherman Place #510 West Hills, CA 91307 | 818-676-4806 |
| Pimstone, Kevin R. M.D. | 1250 La Venta Drive, Suite 207 Westlake, CA 91361 | 805-494-6920 |
| Razeghi, Seyyed Mehdi M.D. | 8510 Balboa Blvd., Suite 150 Northridge, CA 91325-5810 | 818-552-6230 |
| Saedi, Golnaz M.D. | 7320 Woodlake Ave. #170 West Hills, CA 91307 | 818-888-7090 |
| Sahibzada, Afzal H. M.D. | 22110 Roscoe Blvd. #301 West Hills, CA 91304 | 818-719-9117 |
| Shaarawy, Rami M. M.D. | 21822 Sherman Way #100 Canoga Park, CA 91303 | 818-716-0557 |
| Shao, Maogang M.D. | 8510 Balboa Blvd. #150 Northridge, CA 91325 | 818-654-3400 |

7300 Medical Center Dr
West Hills, 91307

| DATE | PATIENT | CODE | DIAG | DESCRIPTION OF SERVICES | AMOUNT |
|---|---|---|---|---|---|
| 08/21/15 | KATHLEEN | 71010/26 | | XRAY:EXAM OF CHEST | $50.00 |
| | | | | Claim 1 Total: | $50.00 |

*To pay this statement electronically go to www.ePayitOnline.com or scan the barcode to the right with your mobile device or tablet*

SCAN FOR MOBILE PAYMENT

**If you would like to pay using a credit card, please visit the secure web site noted at the top of this statement using the indicated Code ID and Access #. For your security purposes, please do not return this statement with your credit card information via the US Mail. If you would like to pay using a check, please detach the top portion of this statement and return it with your check to the address noted above.**

Paid
9/11/2015
# 2981
$50.00

**BALANCE DUE: $50.00**

*ACCOUNT CONDITION:* Current: $50.00 30 Days: $0.00 60 Days: $0.00 90 Days: $0.00 120 Days: $0.00

Patient: KATHLEEN M GOLD Account Number: WVR 10745510 Statement Date: 08/27/2015

Location: WEST HILLS HOSPITAL & M

THIS BILL IS DUE UPON RECEIPT. PLEASE MAIL YOUR REMITTANCE IN THE ENCLOSED ENVELOPE. FOR QUESTIONS PLEASE CALL OUR BILLING OFFICE AT 888 407 3975. THANKS

CMSINC01-0438038-0003934-4825500-001-000478-#004183-0001

**West Valley Radiology Med Group**
PO Box 190
Simi Valley CA 93062

Phone: 888 407-3975

## BILLING & INSURANCE POLICY

You alone, not your insurance company, are responsible for payment of your account. If, after receiving this statement, you are unable to pay in full, you must contact our billing office. If you have reason to believe this billing is incorrect and desire to dispute it, you must notify us in writing within 30 days of receiving this billing. If we do not hear from you, we will expect prompt payment of this bill.

PLEASE NOTE: There may be a collection charge for checks that are not honored by your bank. Also, there may be a service charge added to past due accounts.

We will bill Medicare for you, however, you must provide us with your Medicare number and signed authorization form provided to you at the time of service. If a form was not provided then please sign in the area marked authorized signature above. You will receive a regular monthly billing for any balance owing after payment by Medicare.

## IF YOU HAVE RECEIVED THE SERVICES OF A HOSPITAL OR OTHER MEDICAL FACILITY

YOU MAY RECEIVE TWO SEPARATE BILLS,

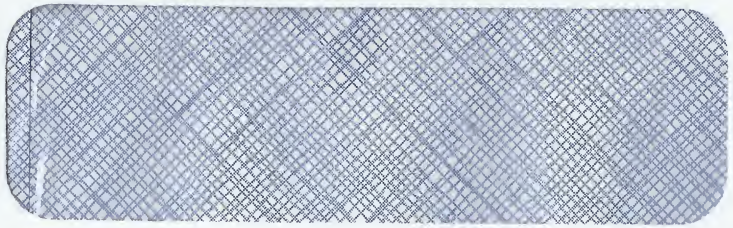
ONE FROM THE HOSPITAL OR MEDICAL FACILITY & ONE FROM THE PHYSICIAN PROVIDING SERVICES.

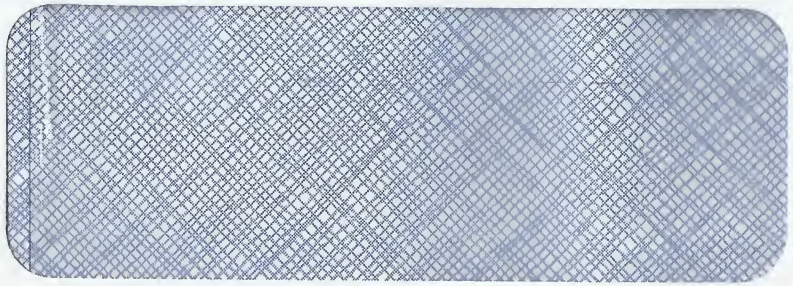
THE HOSPITAL OR OTHER MEDICAL FACILITY'S BILL MAY BE SEPARATE FROM THE PHYSICIAN'S BILL.


The total cost for many medical services may be comprised of two fees. Each fee may be billed separately by the provider of the services.

The hospital or other medical facility's fee covers the cost of providing the technicians, equipment and supplies involved in performance of your service.

The physician's fee is for services provided by your physician or for services provided by a physician for the supervision, interpretation and consultation with your personal physician. The physician is an independent physician and may not be an employee of a hospital or medical facility and therefore may bill separately for his or her professional service.





PRESORTED
FIRST-CLASS MAIL
U.S. POSTAGE PAID
MRH

JWH-SP1 91345


114505

AIN

West Hills Hospital

PO BOX 409434
ATLANTA, GA 30384-9434

SSC08591 312469 187518423

001022

**KATHLEEN M GOLD**
**# 512**
**11100-8 SEPULVEDA BLVD**
**MISSION HILLS, CA 91345-1101**

**We appreciate the opportunity to serve you!**

Thank you for trusting us with your healthcare needs. We hope our care exceeded your expectations. Please contact us if we can be of further assistance.

Pay online at:
www.westhillshospital.com/bill.asp

| **Statement Date:** | **Account Number:** | Page 1 of 1 |
|---|---|---|
| 11/13/2015 | 1002257625 | |

## ACCOUNT ACTIVITY

| | |
|---|---|
| Account Number | 1002257625 |
| Date of Service | 8/21/2015 |
| Charges to Date | $ 2,740.00 |
| UNINSURED DISCO Discounts | - 2,329.00 |
| **Payments/Discounts to Date** | **- $ 2,329.00** |
| **Remaining Account Balance** | **$ 411.00** |
| **Amount Expected From Insurance** | **$ 0.00** |
| ***AMOUNT YOU OWE** | **$ 411.00** |

## A MESSAGE FOR YOU...

Get a new health plan that fits your needs and budget at getcoveredhca.com. Visiting discloses to Enroll America you have been a patient of this hospital.

**This is the hospital bill for Emergency services from August 21, 2015 through August 21, 2015.**

Your current responsibility is $ 411.00

*The amount you owe may include copay, deductibles or non-covered charges.

## PAYMENT OPTIONS

Pay online at www.westhillshospital.com/bill.asp
Available 24/7

Pay with your smart phone by scanning this QR code

Pay-by-phone or call Customer Service at:
800-307-8016 Available Mon-Fri 8AM - 8PM ET

Mail in a check or credit card information with the section below.

Disponible asistencia para el idioma español.

DETACH HERE AND RETURN BOTTOM PORTION WITH PAYMENT

| Patient | Account No. | Date Due | Amount Now Due | Amount Paid |
|---|---|---|---|---|
| KATHLEEN M GOLD | 1002257625 | Upon Receipt | $ 411.00 | $ |

☐ Check here if your address or insurance information has changed. Please indicate changes on the back of this page.

**Please do not send cash.**
**Make checks payable to: WEST HILLS HOSPITAL**

☐ VISA ☐ MC ☐ DISC VER ☐ AMEX

Account No. _____

Expiration Date _____

Authorized Signature _____

**WEST HILLS HOSP & MED CT**
**01554**
**P.O. BOX 740766**
**CINCINNATI OH 45274-0766**

GOLD KATHLEE 00100225762501554000000411000

West Hills Hospital

## CHANGE OF ADDRESS OR HEALTH INSURANCE INFORMATION

If you have new health insurance or a new address, please enter the information below.

| | | | | |
|---|---|---|---|---|
| NEW ADDRESS CITY STATE ZIP CODE | | | | NEW PHONE # |
| NEW EMAIL ADDRESS ☐ *Check here to give us permission to use your email and phone number for billing purposes.* | | | | |
| POLICY HOLDER'S NAME/RELATIONSHIP TO PATIENT | | POLICY ID # GROUP # | | |
| EFFECTIVE DATE | BIRTH DATE OF INSURED | HMO/PPO/OTHER | | INSURANCE PHONE # |
| IF GROUP INSURANCE, NAME OF GROUP (EMPLOYER, UNION/ASSOCIATION) | | | | EMPLOYER PHONE # |
| INSURANCE COMPANY NAME | | INSURANCE ADDRESS | | |
| EMPLOYER | | EMPLOYER ADDRESS | | |

## Notice of Rights

Thank you for selecting this facility for your recent hospital services. Enclosed please find a summary of charges for your hospital visit. **Payment is due immediately.** Please be aware that this is a bill for hospital services only. There may be additional charges for services provided by physicians during your stay in the hospital, such as personal physicians, and any anesthesiologists, pathologists, radiologists, or other medical professionals who are not employees of the hospital. You may receive a separate bill for their services.

**Summary of Your Rights:** State and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8:00 a.m. or after 9:00 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-FTC-HELP (382-4357) or online at www.ftc.gov.

**Credit Counseling:** This facility is aware that non-profit credit counseling services are currently available in this area and we encourage you to contact such services for assistance.

**Health Insurance/Government Program Coverage:** If you have private insurance, Medicare, Medi-Cal, Healthy Families, California Children's Services, or other state funded programs for your health coverage and have not provided that information to us, please call us at the number listed on the enclosed letter so that we may bill your services to the correct health coverage.

If you do not currently have health coverage, you may be eligible for one of these programs, a discount or our charity care program. You may obtain an application for the Medi-Cal or Healthy Families program by calling the same number. We would be happy to assist you.

**Discounted and Charity Care:** If you are uninsured or it is a financial hardship to pay your hospital bill, this hospital has a discount and charity care policy that may reduce or eliminate your financial responsibility to pay the bill. Eligibility is based upon your insurance coverage, financial hardship, and your income and family size. If you believe you may qualify for a discount or charity care, please contact our customer service representatives at the number listed on the enclosed letter.

---

New anh/chi khong the doc hay hieu duc tieng Anh hoac Tay Ban Nha, chung toi co the dich qua tieng Viet co quy vi. Xin goi dien thoai qua van phong lam viec o so tren mieng day nay.

## Noticia de Derechos

Gracias por seleccionarnos para sus servicios medicos. El formulario adjunto solo refleja el monto adeudado en esta cuenta de su visita a nuestro hospital. **Agradecemos su pronto atencion a este balance pendiente.** Por favor esté enterado que esta cuenta es para servicios de hospital sólamente. Es posible que haya cargos adicionales por servicios proporcionados por médicos durante su tiempo en el hospital, como médicos de cabezera, y como los anestesiólogos, los patólogos, los radiólogos, y otros profesionales médicos que no son empleados del hospital. Puede recibir una cuenta separada por esos servicios.

**El resumen de Sus Derechos:** La ley del estado y la ley federal requieren a collectores de deudas para tratarle justamente y prohibe a collectores de deudas de hacer declaraciones falsas o amenazas de violencia, utilizando palabras obscenas o impropias, y haciendo comunicaciones impropias con partidos terceros, incluyendo su empleador. Solamente en circumstancias excepcionales, los collectores de deudas no le pueden contactar antes de 8:00 de la mañana ni después de 9:00 de la tarde. En general, un collector de deudas no puede dar información sobre su deuda a otra persona, unicamente a su abogado o su esposo/a. Un collector de deudas puede communicarse con otra persona para confirmar su lugar o para realizar un juicio. Para más información sobre las actividades de cobro de deudas, usted puede contactar el Federal Trade Commission por teléfono al 1-877-FTC-HELP (382-4357) o en sitio web www.ftc.gov.

**Consejero de Crédito:** Esta facilidad esta consciente que existen consejeros de credito sin fines de lucro de servicios de asesoría de crédito disponibles en la actualidad en este campo y le animamos a contactar los servicios de asistencia.

**Seguro Medico/Seguro Medico de Covertura de Programas del Govierno:** Si tiene seguro medico privado, Medicare, Medi-Cal, Healthy Families, California Children's Services, o otro programa de seguro medico del estado y no nos a proporcionado esa informacion, por favor llame al numero de telefono en esta carta para proporcionar la informacion requerida.

Si usted no tiene seguro medico en este momento, puede tener derechos a unos de estos programas, un descuento o para nuestro programa de caridad. Puede obtener una aplicación para Medi-Cal o para Healthy Families llamando al mismo número. Con gusto le ayudaremos.

**Descuentos y Cuidado de Caridad:** Si usted no tiene seguro medico o es una dificultad financiera a pagar su deuda, este hospital tiene un programa de descuentos o un programa de políza de caridad que puede reducir o eliminar su responsabilidad financiera para pagar la deuda. Elegibilidad se basa en su cobertura de seguro medico, dificultad financiera, y en sus ingresos y tamaño de la familia. Si usted cree que puede calificar por algun descuento o cuidado de caridad, no dude en contactar nuestro servicio al cliente al número indicado en la carta.

FROM _____

_____

_____

☐ CHECK HERE IF ADDRESS CHANGE

159474

PLACE
FIRST
CLASS
POSTAGE
HERE

159474

First Class Mail

PRESORTED
FIRST CLASS MAIL
U.S. POSTAGE PAID
43607
EMDEON EXB

203 IVJ-NP1 91345

MAKE CHECKS PAYABLE TO
West Hills Emergency Medical Associates
PO Box 4419
Woodland Hills CA 91365-4419

005241
0101

**FOR BILLING QUESTIONS**
**Please Call Toll Free:** **888-688-2938**
**Office Hours:** **7:30-5:00 PDT/PST**
**Pay Online:** https://pay.instamed.com/WHEMA

☐ Please check box if address is incorrect or insurance information has changed and indicate change(s) on reverse side.

KATHLEEN M GOLD
11100-8 SEPULVEDA BLVD
#512
MISSION HILLS, CA 91345

| ☐ MASTERCARD | ☐ VISA | ☐ DISCOVER | ☐ AMEX |
|---|---|---|---|
| CARD NUMBER | | AMOUNT | |
| SIGNATURE | | EXP DATE | |

| NOTICE DATE | PAY THIS AMOUNT | ACCT # |
|---|---|---|
| 10/19/2015 | $837.00 | 2257625 |
| PAYMENT DUE BY 11/03/2015 | SHOW AMOUNT PAID HERE $ | |

**PLEASE DO NOT SEND CASH**
WEST HILLS EMERGENCY MED ASSOC
PO BOX 4419
WOODLAND HILLS, CA 91365-4419

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

655601 (PC1)

# SECOND NOTICE

| Patient Name: | KATHLEEN M GOLD | Notice Date: | 10/19/2015 |
|---|---|---|---|
| Account No: | 2257625 | Balance Due: | $837.00 |

This is our second contact concerning your overdue account balance of $837.00.

We are again asking that you pay your account balance in full to avoid further collection proceedings.

If your insurance company has not processed this account for payment, it is possible that we may not have received your insurance information. If you feel this is the case or you have any questions about your account, please call 888-688-2938 and speak with one of our representatives.

Esta es la segunda intencion de comunicarnos con usted acerca de su saldo vencido de $837.00.

Le pedimos que pague el total de su cuenta para evitar futuros procedimientos de coleccion.

Si su aseguranza no ha procesado el pago de la cuenta, es posible que no hemos recibido la informacion de su aseguranza. Si este es el caso o tiene algura pregunta, por favor llamar 888-688-2938 y hable con un representante.

| **Make Checks Payable To:** | **Pay Online at:** |
|---|---|
| WEST HILLS EMERGENCY MED ASSOC<br>PO BOX 4419<br>WOODLAND HILLS, CA 91365-4419 | https://pay.instamed.com/WHEMA |

0000005254-A

2830-PHYCHCSTMT-2878363-2042470772-P; 13441614-1-244; 36710222-1; 1

## IF WE DO NOT HAVE YOUR INFORMATION, OR IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE . . .

### PATIENT INFORMATION

| | | |
|---|---|---|
| Your Name (Last, First, Middle Initial) | | Date of Birth |
| Address | | |
| City | State | Zip |
| Telephone ( ) | | |
| Social Security # | | |
| Employer's Name | | Telephone ( ) |
| Employer's Address | | |
| City | State | Zip |
| Please indicate if Applicable:<br>☐ AUTO ACCIDENT<br>☐ WORKER'S COMPENSATION | | Date of Injury |

### INSURANCE INFORMATION

| | | |
|---|---|---|
| Your **PRIMARY** Insurance Company's Name | | |
| Primary Insurance Company's Address | | |
| City | State | Zip |
| Policyholder Name | Date of Birth | Sex |
| Policyholder's ID Number | | Group Plan Number |
| Your **SECONDARY** Insurance Company's Name | | |
| Secondary Insurance Company's Address | | |
| City | State | Zip |
| Policyholder Name | Date of Birth | Sex |
| Policyholder's ID Number | | Group Plan Number |

**"DETACH HERE AND RETURN ABOVE STUB"**

## FOR HOSPITAL OR OTHER FACILITY PATIENTS

YOU COULD RECEIVE TWO OR MORE BILLS FOR SERVICES PROVIDED

TOTAL DIAGNOSTIC OR TREATMENT COSTS

PHYSICIAN | HOSPITAL

This statement is not a duplicate charge, but a separation of the facility and physician or provider's fees. These services were provided while you were under our care, or at the request of your other physicians or providers.

Your bill from the facility may include a separate charge for use of its equipment, supplies, and technical personnel.

You may also receive bills from other physicians or providers who were involved with your care if you were a patient in the hospital or other facility.

If you have any questions concerning your bill, please call our office and we will be happy to assist you.

**IF YOU REQUIRE ASSISTANCE, YOU MAY CONTACT OUR OFFICE AT THE PHONE NUMBER ON THE REVERSE SIDE.**

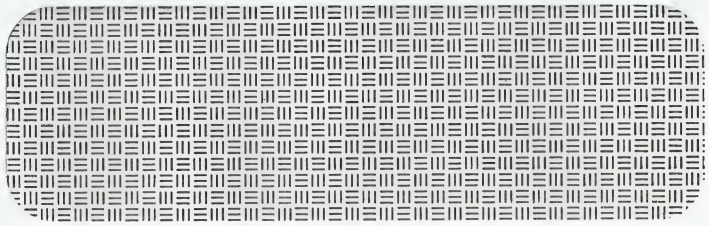
000005254-B

FROM: _____

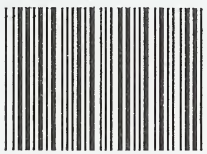
_____

_____

PLACE
STAMP
HERE



ES09



REV.(04/09)U

First Class Mail

PRESORTED
FIRST CLASS MAIL
U.S. POSTAGE PAID
43607
EMDEON EXB

203 IVJ-NP1 91345

ES10

REV.(08/07)

MAKE CHECKS PAYABLE TO
West Hills Emergency Medical Associates
PO Box 4419
Woodland Hills CA 91365-4419

004292
0101

**FOR BILLING QUESTIONS**
**Please Call Toll Free:** **888-688-2938**
**Office Hours:** **7:30-5:00 PDT/PST**
**Pay Online:** https://pay.instamed.com/WHEMA

☐ Please check box if address is incorrect or insurance information has changed and indicate change(s) on reverse side.

KATHLEEN M GOLD
11100-8 SEPULVEDA BLVD
#512
MISSION HILLS, CA 91345

| ☐ MASTERCARD | ☐ VISA | ☐ DISCOVER | ☐ AMEX |
|---|---|---|---|
| CARD NUMBER | | AMOUNT | |
| SIGNATURE | | EXP DATE | |

| NOTICE DATE | PAY THIS AMOUNT | ACCT # |
|---|---|---|
| 11/17/2015 | $837.00 | 2257625 |
| PAYMENT DUE BY 12/02/2015 | SHOW AMOUNT PAID HERE $ | |

PLEASE DO NOT SEND CASH
WEST HILLS EMERGENCY MED ASSOC
PO BOX 4419
WOODLAND HILLS, CA 91365-4419

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

655609 (PC1)

# FINAL NOTICE

| Patient Name: | KATHLEEN M GOLD | Notice Date: | 11/17/2015 |
|---|---|---|---|
| Account No: | 2257625 | Balance Due: | $837.00 |

Our records indicate this account is seriously delinquent. Please contact our office to make payment arrangements. This is our final attempt to contact you to resolve this account. If no response is received within the next 15 days, we will be forced to send this account to an outside collection agency.

Nuestros archivos indican que su cuenta esta seriamente atrasada. Por favor llamenos para hacer un arreglo de pago. Este es el ultimo intento de nuestra parte para resolver esta cuenta si no recibimos respuesta en 15 dias nos veremos forzados a mandarla a una agencia de colleciones.

| Make Checks Payable To: | Pay Online at: |
|---|---|
| WEST HILLS EMERGENCY MED ASSOC<br>PO BOX 4419<br>WOODLAND HILLS, CA 91365-4419 | https://pay.instamed.com/WHEMA |

0000049071-A

2830-PHYCHCSTMT-2913410-2062539426-P; 13574843-1-701; 36826948-1; 1

## IF WE DO NOT HAVE YOUR INFORMATION, OR IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE . . .

### PATIENT INFORMATION

| | | |
|---|---|---|
| Your Name (Last, First, Middle Initial) | | Date of Birth |
| Address | | |
| City | State | Zip |
| Telephone ( ) | | |
| Social Security # | | |
| Employer's Name | | Telephone ( ) |
| Employer's Address | | |
| City | State | Zip |
| Please indicate if Applicable:<br>☐ AUTO ACCIDENT<br>☐ WORKER'S COMPENSATION | | Date of Injury |

### INSURANCE INFORMATION

| | | |
|---|---|---|
| Your **PRIMARY** Insurance Company's Name | | |
| Primary Insurance Company's Address | | |
| City | State | Zip |
| Policyholder Name | Date of Birth | Sex |
| Policyholder's ID Number | | Group Plan Number |
| Your **SECONDARY** Insurance Company's Name | | |
| Secondary Insurance Company's Address | | |
| City | State | Zip |
| Policyholder Name | Date of Birth | Sex |
| Policyholder's ID Number | | Group Plan Number |

**"DETACH HERE AND RETURN ABOVE STUB"**

## FOR HOSPITAL OR OTHER FACILITY PATIENTS

YOU COULD RECEIVE TWO OR MORE BILLS FOR SERVICES PROVIDED

TOTAL DIAGNOSTIC OR TREATMENT COSTS

PHYSICIAN | HOSPITAL

This statement is not a duplicate charge, but a separation of the facility and physician or provider's fees. These services were provided while you were under our care, or at the request of your other physicians or providers.

Your bill from the facility may include a separate charge for use of its equipment, supplies, and technical personnel.

You may also receive bills from other physicians or providers who were involved with your care if you were a patient in the hospital or other facility.

If you have any questions concerning your bill, please call our office and we will be happy to assist you.

**IF YOU REQUIRE ASSISTANCE, YOU MAY CONTACT OUR OFFICE AT THE PHONE NUMBER ON THE REVERSE SIDE.**

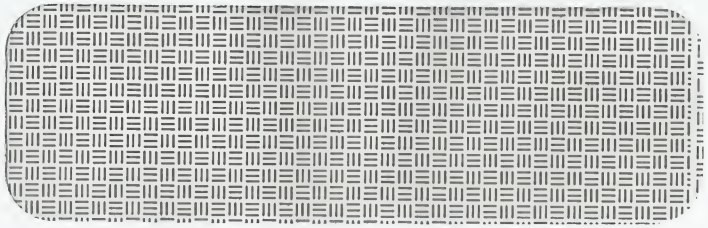
000004907-B

FROM: _____

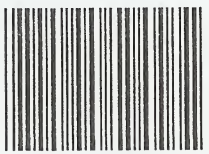
_____

_____

PLACE
STAMP
HERE



ES09



REV.(04/09)U

challenger post office
CANOGA PARK, California
913039998
0581020130-0097
10/20/2015 (800)275-8777 02:27:19 PM

Sales Receipt

| Product Description | Sale Unit Qty | Unit Price | Final Price |
|---|---|---|---|
| WOODLAND HILLS CA 91365-4419 | | | $0.49 |
| Zone-1 | | | |
| First-Class Mail Letter | | | |
| 0.50 oz. | | | |
| Expected Delivery: Thu 10/22/15 | | | |
| @@ Certified Mail | | | $3.45 |
| USPS Certified Mail #: | | | |
| 70150640000504744229 | | | |
| # Return Receipt | | | $2.80 |
| Label #: | | | |
| 9590940301265077636552 | | | |
| Issue Postage: | | | $6.74 |
| Total: | | | $6.74 |

Paid by:
MasterCard $6.74
Account #: XXXXXXXXXXXX6499
Approval #: 617870
Transaction #: 465
23903600179

@@ For tracking or inquiries go to USPS.com or call 1-800-222-1811.

# After delivery, use this tracking number to track your Return Receipt.

Order stamps at usps.com/shop or call 1-800-Stamp24. Go to usps.com/clicknship to print shipping labels with postage. For other information call 1-800-ASK-USPS.

**********
**********
Get your mail when and where you want it with a secure Post Office Box. Sign up for a box online at usps.com/poboxes.
**********
**********

Bill#:1000304832909
Clerk:02

All sales final on stamps and postage

Refunds for guaranteed services only
Thank you for your business

---

HELP US SERVE YOU BETTER

TELL US ABOUT YOUR RECENT
POSTAL EXPERIENCE

Go to:
https://postalexperience.com/Pos
or scan this code with your mobile
device:

or call 1-800-410-7420.

YOUR OPINION COUNTS

---

Customer Copy

**SENDER: COMPLETE THIS SECTION**

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

West Hills Emergency Medical Associates
P.O. Box 4419
Woodland Hills, CA 91365
Attn: Monique

9590 9403 0126 5077 6365 52

2. Article Number (Transfer from service label)

7015 0640 0005 0474 4229

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature

X

☐ Agent
☐ Addressee

B. Received by (Printed Name) Teresa Ferrup

C. Date of Delivery OCT 21 2015

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type

☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

PS Form 3811, April 2015 PSN 7530-02-000-9053 Domestic Return Receipt

7015 0640 0005 0474 4229

**U.S. Postal Service™**
**CERTIFIED MAIL® RECEIPT**
*Domestic Mail Only*

For delivery information, visit our website at www.usps.com®.

WOODLAND HILLS CA 91365 OFFICIAL USE

| | | |
|---|---|---|
| Certified Mail Fee | $3.45 | 0130 |
| Extra Services & Fees (check box, add fee as appropriate) | | |
| ☐ Return Receipt (hardcopy) | $2.80 | |
| ☐ Return Receipt (electronic) | $0.00 | 02 Postmark Here |
| ☐ Certified Mail Restricted Delivery | $0.00 | |
| ☐ Adult Signature Required | N/A | |
| ☐ Adult Signature Restricted Delivery | N/A | |
| Postage | $0.49 | 10/20/2015 |
| Total Postage and Fees | $6.74 | |

Sent To: West Hills Emergency Medical Associates
Street and Apt. No., or PO Box No.: P.O. Box 4419
City, State, ZIP+4®: Woodland Hills, CA 91365

PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions

UNITED STATES POSTAL SERVICE

First-Class Mail
Postage & Fees Paid
USPS
Permit No. G-10

• Sender: Please print your name, address, and ZIP+4® in this box•

Kathy Gold
11100 ~~8~~ Sepulveda Blvd #512
Mission Hills, CA 91345

USPS TRACKING#

9590 9403 0126 5077 6365 52

## Certified Mail service provides the following benefits:

- A receipt (this portion of the Certified Mail label).
- A unique identifier for your mailpiece.
- Electronic verification of delivery or attempted delivery.
- A record of delivery (including the recipient's signature) that is retained by the Postal Service™ for a specified period.

*Important Reminders:*

- You may purchase Certified Mail service with First-Class Mail®, First-Class Package Service®, or Priority Mail® service.
- Certified Mail service is *not* available for international mail.
- Insurance coverage is *not* available for purchase with Certified Mail service. However, the purchase of Certified Mail service does not change the insurance coverage automatically included with certain Priority Mail items.
- For an additional fee, and with a proper endorsement on the mailpiece, you may request the following services:
  - Return receipt service, which provides a record of delivery (including the recipient's signature). You can request a hardcopy return receipt or an electronic version. For a hardcopy return receipt, complete PS Form 3811, *Domestic Return Receipt;* attach PS Form 3811 to your mailpiece; for an electronic return receipt, see a retail associate for assistance. To receive a duplicate return receipt for no additional fee, present this USPS®-postmarked Certified Mail receipt to the retail associate.
  - Restricted delivery service, which provides delivery to the addressee specified by name, or to the addressee's authorized agent.
  - Adult signature service, which requires the signee to be at least 21 years of age (not available at retail).
  - Adult signature restricted delivery service, which requires the signee to be at least 21 years of age and provides delivery to the addressee specified by name, or to the addressee's authorized agent (not available at retail).
- To ensure that your Certified Mail receipt is accepted as legal proof of mailing, it should bear a USPS postmark. If you would like a postmark on this Certified Mail receipt, please present your Certified Mail item at a Post Office™ for postmarking. If you don't need a postmark on this Certified Mail receipt, detach the barcoded portion of this label, affix it to the mailpiece, apply appropriate postage, and deposit the mailpiece.

**IMPORTANT: Save this receipt for your records.**

PS Form **3800,** April 2015 *(Reverse)* PSN 7530-02-000-9047

West Hills Emergency Medical Associates
P.O. Box 4419
Woodland Hills, CA 91365-4419
Attn: Monique

October 20, 2015

Account #: 2257625

Dear Monique,

As per our conversation, I was attacked and because of that attack I had to go into the hospital. In the ER they sat with me and took my information to renew my Medi-Cal to pay for it. They said it wasn't a problem.

I don't know what happened with that application, did it not get renewed or is it in the process, I know there was a backlog of Medi-Cal so maybe that's what's going on, I don't really know I'm just guessing.

You can read about the backlog here:
http://www.dailynews.com/general-news/20150122/californians-stuck-in-medi-cal-backlog-win-lawsuit-against-state

Let me know.

Thank You,

Kathy Gold

West Hills Emergency Medical Associates
PO Box 4419
Woodland Hills CA 91365-4419

**FOR BILLING QUESTIONS**
**Please Call Toll Free:** **888-688-2938**
**Office Hours:** **7:30-5:00 PDT/PST**
**Pay Online:** https://pay.instamed.com/WHEMA

This bill is due and payable upon receipt. Remit payment in the enclosed envelope. If you have insurance, please contact our office.

## Account Detail

| | |
|---|---|
| 08/21/15 | |
| LEV 5,COMP HIST,EXAM,H | $785.00 |
| EKG INTERPRETATION | $52.00 |
| **Total Charges** | **$837.00** |

## Account Summary

| | |
|---|---|
| Patient: | KATHLEEN M GOLD |
| Guarantor | KATHLEEN M GOLD |
| Date of Service | 08/21/15 |
| Account Number | 2257625 |
| Total Charges | $837.00 |
| Total Payments | |
| Total Adjustments | |

**> Your Balance at this time:** $837.00

## Location of Service

West Hills Hospital

## Insurance Information

**Primary Insurance** NO INSURANCE

**Secondary Insurance**

If you are uninsured or have high medical costs, please contact our office at 888-688-2938 for information on discounts and programs for which you may be eligible, including the Medi-Cal program. If you have coverage, please tell us so that we may bill your plan.

0000063604-A

PLEASE DETACH AND RETURN BOTTOM REMIT PORTION WITH YOUR PAYMENT
2830-PHYCHCSTMT-2837760-2019949580-P; 13240795-1-539; 36584671-1; 1

655600 (PC2)

MAKE CHECKS PAYABLE TO

West Hills Emergency Medical Associates
PO Box 4419
Woodland Hills CA 91365-4419

☐ MASTERCARD ☐ VISA ☐ DISCOVER ☐ AMEX

| CARD NUMBER | AMOUNT |
|---|---|
| SIGNATURE | EXP DATE |

**FOR BILLING QUESTIONS**
**Please Call Toll Free:** **888-688-2938**
**Office Hours:** **7:30-5:00 PDT/PST**
**Pay Online:** https://pay.instamed.com/WHEMA

☐ Please check box if address is incorrect or insurance information has changed and indicate change(s) on reverse side.

| NOTICE DATE | PAY THIS AMOUNT | ACCT # |
|---|---|---|
| 09/17/15 | $837.00 | 2257625 |
| PAYMENT DUE BY 10/02/2015 | SHOW AMOUNT PAID HERE $ | |

**PLEASE DO NOT SEND CASH**

004641
0101

KATHLEEN M GOLD
11100-8 SEPULVEDA BLVD
#512
MISSION HILLS, CA 91345

WEST HILLS EMERGENCY MED ASSOC
PO BOX 4419
WOODLAND HILLS, CA 91365-4419

## FOR HOSPITAL OR OTHER FACILITY PATIENTS

YOU COULD RECEIVE TWO OR MORE BILLS FOR SERVICES PROVIDED

TOTAL DIAGNOSTIC OR TREATMENT COSTS

PHYSICIAN | HOSPITAL

This statement is not a duplicate charge, but a separation of the facility and physician or provider's fees.
These services were provided while you were under our care, or at the request of your other physicians or providers.

Your bill from the facility may include a separate charge for use of its equipment, supplies, and technical personnel.

You may also receive bills from other physicians or providers who were involved with your care if you were a patient in the hospital or other facility.

If you have any questions concerning your bill, please call our office and we will be happy to assist you.

**IF YOU REQUIRE ASSISTANCE, YOU MAY CONTACT OUR OFFICE AT THE PHONE NUMBER ON THE REVERSE SIDE.**

000008390-B

## IF WE DO NOT HAVE YOUR INFORMATION, OR IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE . . .

### PATIENT INFORMATION

| | | |
|---|---|---|
| Your Name (Last, First, Middle Initial) | | Date of Birth |
| Address | | |
| City | State | Zip |
| Telephone ( ) | | |
| Social Security # | | |
| Employer's Name | | Telephone ( ) |
| Employer's Address | | |
| City | State | Zip |
| Please indicate if Applicable:<br>☐ AUTO ACCIDENT<br>☐ WORKER'S COMPENSATION | Date of Injury | |

### INSURANCE INFORMATION

| | | |
|---|---|---|
| Your **PRIMARY** Insurance Company's Name | | |
| Primary Insurance Company's Address | | |
| City | State | Zip |
| Policyholder Name | Date of Birth | Sex |
| Policyholder's ID Number | | Group Plan Number |
| Your **SECONDARY** Insurance Company's Name | | |
| Secondary Insurance Company's Address | | |
| City | State | Zip |
| Policyholder Name | Date of Birth | Sex |
| Policyholder's ID Number | | Group Plan Number |

FROM: _____

_____

_____

PLACE
STAMP
HERE

First Class Mail

PRESORTED
FIRST CLASS MAIL
U.S. POSTAGE PAID
43607
EMDEON EXB

017 GAFOAP1 91345

ES09

REV.(04/09)U

ES10

REV.(08/07)

**SENDER: COMPLETE THIS SECTION**

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Parallon
16800 Aston St
Suite 200
Irvine, CA 92606
Attn Pat Flores

9590 9403 0310 5155 6447 11

2. Article Number (Transfer from service label)

7015 0920 0001 3866 3609

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature

X

☐ Agent
☐ Addressee

B. Received by (Printed Name) Dulce Saucedo

C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type

- ☐ Adult Signature
- ☐ Adult Signature Restricted Delivery
- ☐ Certified Mail®
- ☐ Certified Mail Restricted Delivery
- ☐ Collect on Delivery
- ☐ Collect on Delivery Restricted Delivery
- ☐ Mail
- ☐ Mail Restricted Delivery
- ☐ Priority Mail Express®
- ☐ Registered Mail™
- ☐ Registered Mail Restricted Delivery
- ☐ Return Receipt for Merchandise
- ☐ Signature Confirmation™
- ☐ Signature Confirmation Restricted Delivery

PS Form 3811, April 2015 PSN 7530-02-000-9053 Domestic Return Receipt

7015 0920 0001 3866 3609

**U.S. Postal Service™**
**CERTIFIED MAIL® RECEIPT**
*Domestic Mail Only*

For delivery information, visit our website at www.usps.com®.

IRVINE CA 92606

OFFICIAL USE

| | | |
|---|---|---|
| Postage | $ $3.45 | 0420 |
| Certified Fee | $2.80 | 31 Postmark Here |
| Return Receipt Fee (Endorsement Required) | $0.00 | |
| Restricted Delivery Fee (Endorsement Required) | N/A | |
| Total Postage & Fees | $ $6.74 | 09/12/2015 |

Sent To Parallon Attn Pat Flores
Street & Apt. No., or PO Box No. 16800 Aston St #200
City, State, ZIP+4 Irvine, CA 92606

PS Form 3800, July 2014 See Reverse for Instructions

UNITED STATES POSTAL SERVICE

First-Class Mail
Postage & Fees Paid
USPS
Permit No. G-10

• Sender: Please print your name, address, and ZIP+4® in this box•

Kathy Gold
11100-B Sepulveda Blvd #512
Mission Hills, CA 91345

USPS TRACKING#

9590 9403 0310 5155 6447 11

## Certified Mail service provides the following benefits:

- A Certified Mail receipt (this portion of the Certified Mail label).
- A unique identifier for your mailpiece.
- Electronic verification of delivery or attempted delivery.
- A record of delivery (including the recipient's signature) that is retained by the Postal Service® for a specified period.

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- Certified Mail service is *not* available for international mail.
- Insurance coverage is *not* available for purchase with Certified Mail service. However, the purchase of Certified Mail service does not change the insurance coverage automatically included with certain Priority Mail items.
- For an additional fee, you may request the following services:
  - Return receipt service, which provides you with a record of delivery (including the recipient's signature). You can request a hardcopy return receipt or an electronic version. For a hardcopy return receipt, complete PS Form 3811, *Domestic Return Receipt;* attach PS Form 3811 to your mailpiece; include applicable postage to cover the return receipt service fee; and endorse the mailpiece "Return Receipt Requested," or see a retail associate for assistance. For an electronic return receipt, see a retail associate for assistance. To receive a duplicate return receipt, present this USPS®-postmarked Certified Mail receipt to the retail associate, who will provide a duplicate return receipt for no additional fee.
  - Restricted delivery service, which provides delivery to the addressee specified by name, or to the addressee's authorized agent. Include applicable postage to cover the restricted delivery fee and endorse the mailpiece "Restricted Delivery," or see a retail associate for assistance.
- To ensure that your Certified Mail receipt is accepted as legal proof of mailing, it should bear a USPS postmark. If you would like a postmark on this Certified Mail receipt, please present your Certified Mail item at a Post Office™ for postmarking. If you don't need a postmark on this Certified Mail receipt, detach the barcoded portion of this label, affix it to the mailpiece, apply appropriate postage, and deposit the mailpiece.

**IMPORTANT: Save this receipt for your records.**

PS Form **3800,** July 2014 *(Reverse)* PSN 7530-02-000-9047

Kathy Gold
11100-8 Sepulveda Blvd, #512
Mission Hills, CA 91345

Parallon
16800 Aston St, Suite 200
Irvine, CA 92606
Attn Pat Flores

September 11, 2015

Dear Pat Flores,

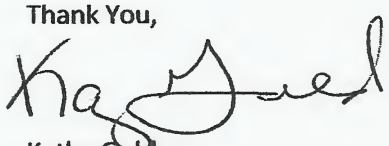
I received your letter dated August 25, 2015 and I called you twice and left you two messages in regards to medicaid application.

I also recieved a final notice dated 9/3/2015 for medical.

I really don't understand this at all as I did the paperwork for my medical renewal at West Hills Hospital in the emergency room. I only recieved one message from you which I called back last week.

Feel free to contact me via email at info @kathygold.com. Maybe you can email me the paperwork you need me to fill out.

Thank You,



Kathy Gold

16800 Aston Street Suite 200
Irvine CA 92606-4822

16800 Aston St. STE 200 • Irvine, CA 92606
(949) 430-5200 / (800) 494-4257 • Fax (949) 430-5220
RCPSDLMedicaidCustomerService@Parallon.com

Tuesday, August 25, 2015

Kathleen Gold
11100-8 Sepulveda Blvd # 512
Mission Hills CA 91345-1101

Re: Medicaid application on behalf of Kathleen Gold

Dear Kathleen Gold:

Our office has been asked by Hca to help you apply for Medicaid benefits for your hospitalization on 08/21/2015. Please be aware that you are responsible for payment of all medical bills relating to this hospital stay. However, if you qualify for Medicaid you will receive assistance to pay for your hospital bills, as well as other medical bills.

Our service is provided free of charge to you. We are not a collection agency!

Please call me within 15 days from the date of this letter by **09/09/2015**. I may be able to help you even if you have applied for Medicaid and your application was denied. **My toll-free telephone number is listed below.**

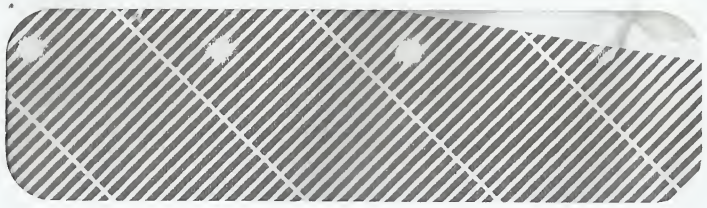
IMPORTANT: Please note, if you already have eligibility coverage to pay your hospital bill, please call me right away so that I can verify your benefits for billing.

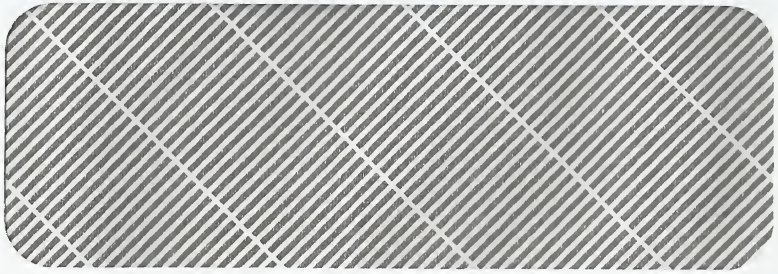
Respectfully,

Pat Flores
Specialist
855-898-6257

FILE NUMBER: 1561749

668743155_213CSTOGC04INTROEN





PRESORTED
FIRST-CLASS MAIL
U.S. POSTAGE PAID
DPCH

00150827DD

PARALLON

16800 Aston St. STE 200 • Irvine, CA 92606
(949) 430-5200 / (800) 494-4257 • Fax (949) 430-5220

**Thursday, September 03, 2015**

Kathleen M Gold
11100-8 SEPULVEDA BLVD APT 512
MISSION HILLS, CA 91345

**FINAL NOTICE**

Re: Medi-Cal application on behalf of Kathleen M Gold
Hospital: HCA-West Hills Hospital and Medical Center (CA)
Admit Date: 8/21/2015

Dear Kathleen M Gold:

Our office is contracted with HCA-West Hills Hospital and Medical Center (CA) to help their patients apply for Medi-Cal benefits as well as resolve problems or difficulties with their existing Medi-Cal case.

There is no charge to you for this service. We are not a collection agency!

I have been trying to contact you in order to assist you in obtaining Medi-Cal coverage that will help you pay your outstanding medical bills. However, I have not heard from you and there is only a limited amount of time remaining to help you. I would very much like to assist you. If I do not hear from you within 10 days by **9/13/2015,** I will no longer be able to help you.

Please call me right away!

Respectfully,

Pat Flores
Medi-Cal Specialist
855-898-6257
949-430-5220 fax

FILE NUMBER: 1561749

PARALLON
16800 Aston Street, Suite 200 • Irvine, CA 92606

U.S. POSTAGE PITNEY BOWES
ZIP 92606 $ 000.48[5]
02 1W
0001379946 SEP 03 2015

91345@1101 C059

West Hills Hosp. & Med Ctr
P O Box 923508
Norcross GA 30010-3508

November 12, 2015

KATHLEEN M GOLD
11100-8 SEPULVEDA BLVD
#512
MISSION HILLS,CA 91345

Patient Name: KATHLEEN M GOLD
Patient Account#: 1002257625
Service Date: 08/21/2015 - 08/21/2015

Dear KATHLEEN M GOLD:

This letter is being sent to notify you that your charity write off request has been denied due to the Financial Assistance Application not being received.

The account balance is due now. Payment may be made by check, money order, or credit card. If you are paying by check, please include your account number on the check.

You may appeal the denial decision by submitting a written request for review. Remember to include any previously missing or additional documentation to support your written request. This request must be returned within 30 days of the date of this letter. You will receive a written response to your appeal request within 30 days of the letter's receipt. If you have any question or concerns, please contact us at the number listed below.

If payment has been made since the date of this letter, please disregard this request. Thank you for choosing West Hills Hosp. & Med Ctr for your healthcare needs. If you have any questions or concerns, please contact us at the number listed below.

Sincerely,
Customer Service
Phone:800-307-8016

Credit Card Authorization:
When paying by credit card, check the appropriate card and complete the information below.
[ ] Visa [ ] American Express [ ] MasterCard [ ] Discover
Card Number:_____Expiration_____
Date_____Payment: $_____
Signature of Cardholder: _____

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